entire unamortized discount (premium) and unamortized fees associated with refinanced debt will be allowed as of the date of refinancing as recognized for cost reporting purposes.

2. Amortized property expenses. Amortization of bond discounts and premiums are to be considered an element of interest expense. Letter of credit fees related to a letter of credit used only as collateral for obtaining long term financing (bonds, mortgages, etc.) shall be allowed as property.

3. Depreciation expense. Depreciation expense must be calculated under a straight-line method over a useful life, consistent with generally accepted accounting principles (GAAP). Useful lives will be determined by reference to the useful lives guidelines published by the American Hospital Association.

3.525(a) Minimum Useful Life for Plant Assets

Depreciation for either the initial construction of buildings or building additions (including fixed equipment and land improvements) must be based on a minimum useful life of 35 years from the earlier of: 1) the date of initial licensure of the facility as a nursing home or other health care facility, or 2) the date of initial occupancy. Remodeling projects of existing licensed facilities will be depreciated according to American Hospital Association (AHA) guidelines for each of the individual components of the project. A minimum estimated useful life of 20 years will be applied to facilities purchased after July 1, 1988. New movable equipment will be depreciated according to AHA guidelines. The minimum estimated useful life for purchases of used movable equipment will be 5 years. This life will be applied to the composite value of the purchased equipment.

3.525(b) Expenses Directly Related to Establishing Units for Services to Ventilator Dependent Residents

A facility's additional expenses for depreciation and interest directly related to establishing a unit for ventilator dependent residents may be exempted from the limitations and maximums under Sections 3.500. "Directly related" means that the costs have been incurred solely as a result of creating this unit and the equipment acquired or remodeling performed benefits only this unit. Prior approval by the Department (i.e., Administrator of the Division of Health Care Financing) of the remodeling project or equipment acquisition is required. This adjustment is only available for projects completed after July 1, 1993.

3.526 Interest Expense

Generally, interest expense on loans for acquisition of nursing home plant assets and equipment is an allowable property-related expense. Interest expense must be reasonable and necessary to be considered allowable. "Necessary" means that the interest is incurred on a loan necessary to satisfy a financial need and for a purpose reasonably related to nursing home resident care. Allowable interest expense on debt incurred for the acquisition of land, land improvements, buildings, leasehold improvements, and fixed and movable equipment related to nursing home patient care is a property-related expense.

3.526(a) Basis for Allowable Interest Expense

Allowable interest expense is based on:

1. Proper accrual under Section 1.302;
2. Recognizable debt balances under Section 3.526(b);
3. A "systematic reduction of debt" under Section 3.526(c);
4. Financing terms that would be incurred by a "prudent buyer" at the time a debt is created; and
5. The net amount remaining after investment income is offset.

3.526(b) Recognizable Debt Balances

Interest expense will be allowed only on debts which:

First, are for the acquisition of the plant assets listed in Section 3.526 that are directly related to nursing home patient care;

Second, have been limited or allocated, if necessary, under Section 3.522; and

Third, are for the original asset acquisition plus the second & third cost report year after a loan has been taken out, we will add the amount of asset purchases to the assets purchased the first year of the loan to determine maximum financing allowed. The recognized debt balance will be adjusted when the additional assets flow through the aforementioned cost reports.

Fourth, do not exceed 110% of Equalized Value per Section 3.531(b).

3.526(c) Systematic Reduction of Debt
Allowable interest expense may not exceed the amount which would have been incurred under a systematic reduction of debt. The calculation of this limitation varies based on whether a facility makes at least annual principal payments or deposits to a segregated interest-bearing account.

If a facility makes at least annual principal payments or deposits to a segregated, interest-bearing account which will result in repayment of the debt at maturity, a systematic reduction of debt means a debt which has:

1. Payments of interest and principal which are uniform over the total length of debt; and
2. A length not exceeding the lesser of forty (40) years or the remaining useful life of the longest lived asset acquired with debt proceeds.

Allowable interest expense is predicated upon required systematic reduction of debt.

If a facility does not make at least annual principal payments or deposits, a systematic reduction of debt will be determined by the Department through:

1. An amortization schedule for a period of thirty (30) years from the date of asset acquisition;
2. Applying the interest rate as stated in the debt contract;
3. For debt contracts entered into prior to July 1, 1990, assuming a principal reduction schedule beginning July 1, 1990, and ending thirty (30) years from the original loan date; and
4. Reducing the calculated interest expense by any investment income on segregated funds.

3.526(d) Interest Expense Related to Refinancing of Debt Effective with the 2000 cost report
The recognizable debt balance following refinancing will be determined as:

Long Term Debt
1. The remaining balance of the original debt as determined under Sections 3.526(b) and 3.526(c); plus
2. The cost of assets acquired in the year of refinancing and then adjusted the following two fiscal years for additional assets acquired; plus

Separate short term Working Capital
1. The financing fees related to the refinancing

The allowable interest expense for refinancing arrangements may not exceed the amount which would have been allowed on the recognizable debt balance, excluding financing fees, had the refinancing not occurred.

Systematic reduction of debt under Section 3.526 is required for refinancing arrangements.

3.526(e) Reduction for Investment Income
The allowable interest expense after applying Sections 1.270 and 3.526(a)1 through 4 will be reduced by the amount of any investment income of the facility or related entities, including foundations, home offices, etc. per Section 1.270, to the extent that total property related expenses exceed the Target (T1) described in Section 3.532. Investment income offset will not include income from donor-restricted funds provided that there is separate accounting for such funds, that the funds are used for their intended purpose, and there is no future benefit to the donor, grantor, or endower. Reserves needed by Continuing Care Retirement Centers to offset lifetime contracts can be calculated by their actuaries if lifetime contracts do not require residents to apply for Medicaid if the resident's fund are exhausted.

3.527 Property Insurance
Allowable property insurance expense will be the accrual-based expense from the base cost reporting period. This expense will be subject to allocations for revenue-producing areas and for non-nursing home areas. Allowable property insurance expense includes mortgage insurance required by the lender.

3.528 Inadequate Documentation
Where the provider, or in the case of changes of ownership, the buyer or seller of a nursing home, is unable or unwilling to provide adequate documentation of acquisition cost, acquisition date or other data relevant to the property-related expenses, or if the provider does not comply with property documentation requests by the Department or the contractor under Section 3.531, the Department will determine the values, dates and data through use of secondary sources of information, such as income and property tax records, and may use the source which results in the lowest value or the lowest property payment allowance.

3.530 Calculation of Property Allowance

3.531 Equalized Value

The equalized value will be derived from the values determined by an independent contractor under contract with the Department, using the E. H. Boeckh Commercial Valuation System. Any values established by such contract will be indexed, if necessary, to the current rate year. The equalized value will be the Depreciated Replacement Cost (DRC) from the E. H. Boeckh valuation after adjustment under Sections 3.531(a) and (b). These values will not be modified by any sales price; by a market appraisal by a certified appraiser on behalf of the facility; or by the assessed value on the property tax rolls.

The total value of the facility will be the sum of the values determined for the separate sections of the facility.

A facility's equalized value shall be based upon the values determined above, including adjustments, unless the facility does not render payment under Section 4.697 within a reasonable time period. In such instance, the facility's property allowance will be reduced by applying fifty percent of the facility's June 30, 2001, DRC and Undepreciated Replacement Cost (URC) under Section 3.531(b) or by fifty percent of the facility's June 30, 2001, property allowance, whichever is lower. This reduction applies to both the interim rate granted, if any, and the final rate. Upon facility payment of the appraisal cost, this reduction will be restored on a retroactive basis to the effective date of the reduction, and the facility property allowance will be calculated as determined by the provisions of the Methods.

3.531(a) Allocation for Areas Not Related to Routine Services

The values derived from the Boeckh valuation will be adjusted to exclude the value of areas not related to routine services. To the extent possible, this adjustment will be based on the square footage used in the Boeckh valuation.

3.531(b) Maximum on Equalized Value

The Undepreciated Replacement Cost (URC) arrived at under the Boeckh valuation system shall not exceed the equalized value in Section 5.830 times the beds for rate setting (Section 3.040) for allowances calculated under this Methods. Where this maximum is exceeded, the equalized value will be adjusted proportionately. This calculation can be expressed as follows:

For: Boeckh URC = The Boeckh Undepreciated Replacement Cost after Section 3.531(a) square footage adjustments;

Boeckh DRC = The Boeckh Depreciated Replacement Cost after Section 3.531(a) square footage adjustments

URC = Allowable Undepreciated Replacement Cost (the lesser of Boeckh URC or the equalized value in Section 5.830)

Then allowable Equalized Value (EV) is calculated as:

EV = (Boeckh DRC/Boeckh URC) X URC

3.532 Property Allowance Calculation

A target amount (T1) will be calculated for each facility by multiplying the equalized value from Section 3.531 by a service factor described in Section 5.820 (a).

When a facility's allowable property-related expenses are less than the target amount (T1), the property payment allowance will be allowable expense plus the incentive value in Section 5.850 times the amount by which expense is less than the target (T1). When the facility's allowable property-related expenses are equal to or greater than the target amount, the property payment allowance will be the target amount plus 100% of the amount by which allowable expense exceeds the target up to the factor in Section 5.820 (b), and the cost share value in Section 5.840 times the amount by which allowable expenses under Section 3.521 exceed the factor in Section 5.820 (b).

This calculation can be expressed:

For:
- E = Allowable property-related expenses up to Section 3.521 maximum;
- T1 = The service factor in Section 5.820 (a);
- T2 = The service factor in Section 5.820 (b);
- PA = Total property payment allowance;
- I = Increment described in Section 5.810;
- C = Cost Share Value described in Section 5.840; and
- N = Incentive described in Section 5.850.

Then: Where E is less than T1:

$$PA = (E + N * (T1 - E)) + I$$

Where E is equal to or greater than T1 and E is less than T2:

$$PA = E + I$$

Where E is greater than T2:

$$PA = (T2 + C * (E-T2)) + I$$

Facilities which have completed a Ch. 150 Resource Allocation Program approved project involving construction or renovation of physical plant between July 1, 1996, and December 31, 1997, will have a cost share percentage as described in Section 5.840(b). Nursing facilities that have a licensed bed capacity of 50 beds or less, after adjustments in Section 3.000, will have a cost share as described in Section 5.840(b). Facilities that are certified as ICF/MR, either in whole or in part, will have a cost share as described in Section 5.840(a), unless they have completed a RAP-approved project as noted above.

3.534 Per Patient Day Property Payment Allowance

To calculate the per patient day property payment allowance, the property allowance (Section 3.532) is divided by the adjusted patient days in Section 1.307 times the minimum occupancy factor in Section 3.030. If needed, the expenses shall be adjusted to the length of time covered by the patient days.

For calculating the per patient day property payment allowance for newly-licensed facilities and facilities with significant licensed bed increases, the patient day provisions of Sections 4.320 and 4.420 will apply. For replacement facilities, the minimum occupancy standard in Section 3.030 will be applied.

3.537 Maximum Decrease

A facility's payable property allowance will not be reduced by more than $3.50 per patient day from the allowance in effect on June 30, 2001. An exception to this maximum decrease is made if the June 30, 2001, allowance is subject to adjustment after June 30, 2001, for the lapsing of the "start-up" occupancy provisions for newly-licensed or expanded facilities. In these cases, the $3.50 maximum reduction is measured from the allowance which would have resulted from applying the Methods in effect on June 30, 2001.

3.600 OVER-THE-COUNTER DRUGS ALLOWANCE

Reimbursement for certain over-the-counter (OTC) drugs ordered by a physician and provided to Wisconsin Medicaid residents shall be made as part of the facility's daily rate. The OTC allowance will be based on the facility's cost of OTC services for Wisconsin Medicaid residents from the base cost reporting period, as limited by the provisions under Section 2.600.

Payment for OTC drugs will be determined using the following formula:

For: P = OTC allowance;
E = Facility's allowable expense for Wisconsin Medicaid resident OTC drugs as adjusted to the common period by an inflation/deflation factor (Inflation factors are listed in Section 5.330); divided by adjusted Medicaid patient days

Emin = Expense at minimum occupancy,

E * Minimum Occupancy Factor in 3.030

CMI-T19 = From Section 3.122

T = Target for OTC expense in section 5.910 * CMI-T19
I = Inflation rate to payment period by inflation factor listed in Section 5.910; and

If Emin is less than T

P = (Emin* x I) +0.25 (T-Emin)

If Emin is greater than T

P = (TxI) + .75 (Emin-T)

3.650 PROVIDER INCENTIVES

3.651 Exceptional Medicaid/Medicare Utilization Incentive

Payment for the EMMUI supplement will be determined using the following formula:

$$EMMUI = F \times BA$$

where F = The facility's adjusted Medicaid patient days plus Medicare patient days divided by the facility's adjusted total patient days under Section 1.307. F must be greater than or equal to 70.0% in order to receive the EMMUI.

and BA = The base allowance in Section 5.920

3.652 Energy-Savings Incentive

If a facility completes a remodeling or renovation project specifically designed to reduce consumption of electricity or heating fuels, or to reduce their electricity or heating fuel rates per unit of energy, the facility will receive an incentive equal to the lessor of 25% of the projected cost of the project, as approved by the Department, or 25% of the actual cost of the project per year for two years. The incentive payment will be effective July 1 following completion of the project. Allowable costs for the project will be subject to minimum occupancy factor under Section 3.030.

3.653 Private Room Incentive

a. Basic Private Room Incentive (BPRI)
A basic private room incentive will be determined using the following formula:

BPRI = PRP x BBA

where PRP = Private rooms divided by total licensed beds on the last day of the cost report used for the rate calculation. PRP must be greater than or equal to 15% **AND** the facility's adjusted Medicaid patient days plus Medicare patient days divided by the facility's adjusted total patient days under Section 1.307 must be greater than or equal to 70% in order to receive the BPRI

and BBA = The basic base allowance in Section 5.930

b. Renovation Private Room Incentive (RPRI) and Replacement Private Room Incentive (RPPRI)
A renovation private room incentive or replacement private room incentive will be determined using the following formula:

RPRI or RPPRI = PRP x RBA

where PRP = Private rooms divided by total licensed beds on the last day of the cost report used for the rate calculation. PRP must be greater than or equal to 90% **AND** the F from Section 3.651 must be greater than or equal to 70% in order to receive the RPRI or RPPRI.

and RBA = The renovation base allowance in Section 5.930

A facility may receive only one incentive.

3.700 FINAL RATE DETERMINATION

3.710 General

Sections 3.710 through 3.770 describe the process for determining a facility's final payment rate by level of care for direct care services, support services administrative and general, fuel and other utility expense, over-the-counter drug expenses and property taxes. This process shall be followed whenever any payment allowance under Sections 3.100, 3.200, 3.250, 3.300, 3.400 or 3.600 is adjusted or recalculated. Any average amount under this section shall be the average as weighted by the adjusted patient days by level of care which were used in calculating the direct care allowance under Section 3.100. The Department shall specify the patient day period.

3.720 Base Rate

3.721 Base Rate Described

A facility's base rates shall be the total rates effective for each level of care for services rendered on June 30, 1994, excluding the capital allowance, ancillary add-ons, special allowances for local government-operated facilities and rate adjustments made by the Nursing Home Appeals Board, but including reimbursement for over-the-counter drugs under Section 3.600. An average base rate shall be calculated under Section 3.710 for each facility.

3.722 Base Rate Modification

The base rates shall be modified according to the following:

1. Adjustments. Base rates shall include any audit adjustments or corrections subsequent to June 30, 1994, that are deemed effective for date-of-service June 30, 1994.

2. Certification or Licensure Change. Upon a change in certification or licensure level of the facility, the base rate for any added level of care, for which no base rate exists, shall be the base rate from the next lower level of care.

3. Newly-Licensed Beds. A newly-licensed facility which is in its start-up period as of June or July 1994 shall have zero base rates. A facility with significant licensed bed increases which is in its start-up period as of June or July 1994 shall have as its base rates those rates effective at the end of the month prior to the licensure of the new beds.

   Such base rates shall be limited for the current rate calculation to a maximum which shall be the facility's average base expense as determined in Section 3.731. If the average base rate is limited by the maximum, base rates for each level of care shall be calculated by multiplying the unlimited base rates for each level of care by a ratio of the maximum divided by the unlimited average base rate.

4. Temporary Bed Reductions. If the June 30, 1994, base rates were retrospectively adjusted for temporary bed reductions due to renovation projects, such rates shall be the base rates for application of this section until completion of the renovation period. After completion of the renovation period, the base rates shall be those rates effective for date of service June 30, 1994, prior to the retrospective rate adjustment for recognition of the temporary bed reduction.

3.730 Projected Expense

The projected expense shall be the sum of the average expense per patient per day, which was used in the calculation of each allowance in Sections 3.100 through 3.400 and 3.600, after being adjusted to the payment year as follows:

1. Direct care inflation adjusted expense from Section 3.120 shall be inflated by 3.4%.
2. Support services expense from Section 3.220 shall be inflated by 3.4%.
3. Administrative and general services expense from Section 3.250 shall be inflated by 3.4%.
4. Fuel and utility expense from Section 3.310 shall be inflated by 3.4%.
5. The property tax expense from Section 3.400 shall be inflated by 3.4%.
6. Over-the-counter drug allowance from Section 3.600 shall be inflated by 3.4%.

3.740 Current Methods Rate

A facility's current Methods rate for each level of care shall be the sum of the payment allowances resulting from Sections 3.100 through 3.400 and 3.600. A weighted average current Methods rate shall be calculated

3.760 Hold-Harmless Rate

The facility's average hold-harmless rates shall be the base rates under Section 3.720.

3.770 Selection of Payment Rate

3.772 Hold-Harmless Rate

The hold-harmless rates under 3.760 shall be the facility's payment rates if both of the following conditions are met:

1. The average current Methods rate under 3.740 is less than the average base rate under 3.720.
2. The average current Methods rate is less than the projected expense under 3.732.

3.773 Current Methods Rate

The current Methods rates under Section 3.740 shall be the facility's payment rates if Section 3.772 does not apply.

3.774 Final

The property allowance determined under Section 3.500 and ancillary add-ons determined under Section 3.800 shall be added to the rates selected under Sections 3.772 or 3.773 above. The sum shall be the payment rates for the facility.

3.775 Special Allowances for Facilities Operated by Local Units of Government

A. In recognition of the unique nature of nursing homes operated by local units of government, local government-operated homes are eligible to apply for supplemental funding.

   1. In order to participate in the supplement, the home must have on file with the Department and/or submit the following materials:

      a. A cost report as required in Section 1.170.

      b. A prospective supplemental award application form.

   2. Supplemental funds awarded to the home will be made in lump sum payment(s).

3. Total supplemental funding shall not exceed $77,100,000. The Department shall reduce the supplemental funding to the local units of government if it determines that the aggregate payments to nursing homes under these Methods would exceed the Medicare upper limit.
4. The following methodology will be used to distribute funds under this Section:

   a. Based upon the cost report and the rates established under the Methods, the Department will determine the following Medicaid deficits:

      1. The Projected Direct Care Operating Deficit (DCOD)
      2. The Projected Overall Operating Deficit (OAOD)
      3. The Eligible Direct Care Deficit (EDCD) (Equal to the lesser of the DCOD or the OAOD)
      4. The deficit for the facility's governmental phase down settlement (GPDS)
      5. The deficit for the facility's governmental interim payment (GID).

   The Department will issue a report to each applicant facility detailing its DCOD and OAOD.

   b. The Department will distribute $77,100,000 in supplemental funding as follows:

      The mean EDCD will be determined for all eligible facilities.

Phase I Direct Care Payment

1. If the sum of the EDCD for all eligible facilities is less than $77,100,000, the EDCD will be paid.
2. If the sum of the EDCD for all eligible facilities is greater than $77,100,000 and the sum of the deficits up to the mean is less than $77,100,000, the payment to each facility will be the lower of their EDCD or the mean EDCD plus a pro-rated portion of the available funds based on the amount in excess of the mean EDCD.
3. If the sum of the EDCD for all eligible facilities is greater than $77,100,000 and the sum of the deficits up to the mean is greater than $77,100,000, all awards in Phase I will be reduced proportionately.

If all funds are used in Phase I, Phases II, III and IV do not apply

Phase II Final Settlements. All government nursing homes that complete an approved phase down between 7/1/01 and 6/30/02 are eligible for a final settlement. The governmental phase down settlement (GPDS) will be calculated according to section 3.775 (C)(3) and be reduced by the deficit paid in Phase I for a proportionate time period. If funds available after Phase I is completed are not sufficient to pay the full GPDS to all homes, the amounts will be reduced proportionately and Phases III and IV will not apply.

Phase III Interim Payments. All eligible nursing homes listed in 3.775(C)(1) that do not complete a phase down during the reimbursement period, are eligible for an interim payment. The governmental interim payment (GID) will be calculated according to section 3.775 (C)(4). If funds available after Phase II is completed are not sufficient to pay the full GID to all homes, the amounts will be reduced proportionately and Phase IV will not apply.

Phase IV Remaining funds. Homes with an OAOD remaining after the supplement in Phase I will receive a payment if funds remain after Phase III. Nursing homes will not be eligible for any Phase IV funds during any phase down period. If funds available after Phase III is completed are not sufficient to pay the full amount remaining to all homes, the amounts will be reduced proportionately.

B. Subject to the availability of county, State, and Federal funds, and based upon a transfer agreement and the subsequent transfer of funds, the Department will make supplemental payments in addition to the amount under Section A.3., to government operated nursing homes as provided subsections 1 and 2.

   1. To qualify for exceptional payments under the Medicaid program, a nursing home must meet the following criteria:

      a. Meet the participation requirements set forth in Section A; and

      b. Be located in a county where and based on the home's fiscal year 2000-2001 Medicaid cost report, either:

         i. provide at least 108,000 days of care to Medicaid residents and incur a gross deficit for Medicaid of at least $3 million; or projected Medicaid deficits, for the 2000/01 rates year, for all nursing homes owned and operated by the county totaled at least $4,500,000.

         ii. provide between 80,000 and 108,000 days of care to Medicaid residents and incur a gross deficit for Medicaid of at least $4.0 million. Adjusted Medicaid patient days from the 1999 cost reports for all facilities owned and operated by the county totaled at least 80,000.

      c. The county board passed a resolution by June 30, 2001 to downsize the facility during the current payment period.

2. Local government-operated homes qualifying for exceptional payments under subsection 1 will receive an exceptional nursing home payment determined as follows:

   a. For each State Fiscal Year, the Department will calculate the maximum additional payments it can make in conformance with 42 CFR 447.272;

   b. The Department will determine the total additional payments to be made to qualifying nursing homes in a manner not to exceed the maximum amount determined in 2.a.;

   c. The Department will determine the total Medicaid costs for each qualifying nursing home using the most recent cost reports on file with the Department;

   d. The Department will divide the Medicaid costs for each qualifying nursing home by the total Medicaid costs for all qualifying nursing homes to determine each qualifying nursing home's payment factor; and

   e. The Department will determine each qualifying nursing home's exceptional payment amount by multiplying the nursing home's payment factor calculated in 2.d. by the total additional payment amount determined in 2.b. to establish the exceptional payment for the nursing home.

C. Supplemental Payment for Significant Decreases in Licensed Beds.

1. Eligible Nursing Homes -- Local government-operated nursing homes are eligible for the supplement if they meet the following:

   a. The county board or governing body of the local unit of government passed a resolution by June 30, 2001 to downsize the facility during the current payment period;
   b. The reduction began on or before June 30, 2001;
   c. The downsizing will result in a decrease in licensed bed capacity that is the lesser of: (1) a reduction that is greater than or equal to 25.0% of the previously unrestricted use beds or (2) 50 beds; and
   d. Nursing homes eligible for payment under this section may not receive payment adjustments under section 4.500 for the same period.

2. Phase-Down Period

   The phase-down period is that time period during which the resident population may be reduced and during which licensed beds are being reduced to the objective bed capacity. The provider shall submit a written plan for the phase-down acceptable to the Department. The plan must specify the objective licensed bed capacity, the expected date by which any phase-down of the resident population is to begin, the amount of the phase-down, and the expected date by which the license will be amended to the objective capacity. The Department shall establish the beginning and ending dates of the phase-down period, which may be modified as needed during the phase-down.

3. Final Settlement

   a. Nursing homes that complete a phase down during the reimbursement period will receive a final settlement from the first day of the reimbursement period to the end of the phase-down period.
   b. Nursing homes that received an interim payment under this section for a prior period will receive a final settlement for the interim payment period.
   c. Nursing homes that receive a final settlement shall file a cost report on forms provided by the Department for the settlement period.
   d. Based on the cost report, the rates established under the Methods, interim payments and any other payments for nursing home services, the Department will determine the deficit for Medicaid residents. This deficit will be referred to as the governmental phase down settlement (GPDS).

4. Interim Payment

   a. Nursing homes that are in a phase-down during the entire reimbursement period, will receive an interim payment rate.
   b. Nursing homes that receive an interim rate shall file a projected cost report on forms provided by the Department for the interim period. The report shall include projected nursing home expenses and projected Medicaid and Total patient days.
   c. Based on the cost report, the rates established under the Methods and any other payments for nursing home services, the Department will determine the deficit for Medicaid residents. This deficit will be referred to as the governmental interim deficit (GID)

3.780 Wage Pass-Through Supplement

Effective July 1, 2001, facilities may receive a wage pass-through supplement if they applied for the supplement and filed an appeal with the Department prior to January 30, 2001. The amount to be paid will be the maximum amount as calculated according to section 3.780 of the state plan effective July 1, 2000, less any wage pass-through payments made by June, 30, 2001.

3.790 Purchased Relocation Services

Payment for relocation services may be paid as a lump sum, in addition to the daily payment rate, if all of the requirements listed below are met.

- The relocation plan(s) must be ordered by the Department
- The Department must approve the contractor performing the services.
- Only services such as assessment of the resident for alternate placements, preparing contracts for community-based services and developing the community-based care provided by and paid to an outside contractor are allowable. All staff costs are allowable in the Methods and are not eligible for the lump sum payment.
- The amount allowed must meet all Departmental contracting limits.

The Department will pay the Medicaid portion of the allowed Purchased Relocation Services. The percentage of residents that were Medicaid during the month prior to the relocation order will be used as the Medicaid portion. The Department may, at their sole discretion, pay 100% of the allowed Purchased Relocation Services if the request is made prior to contract signature and it is shown to be in the Departments best interest.

Example: The Nursing Home receives a relocation order from the Department on July 15. They hire Apex Relocation Services to relocate all 100 residents in the next 60 days for a cost of $15,000. The Department approves the contract with Apex and the contract amount of $15,000. During June, 75 of the 100 residents were paid through Medicaid. Therefore, $11,250 ($15,000* 75%) will be paid to The Nursing Home as a lump sum.

If this section does not apply, the relocation services will be included in the cost report and paid accordingly.

3.800 ANCILLARY BILLABLE ITEMS

3.801 Medical Transportation

Medical transportation may be separately billed by a nursing home provider as an ancillary. Billings may not exceed the nursing home's actual cost. A per patient day ancillary add-on to the payment rate may be allowed for the cost of transportation services, but not to exceed the amount which would have been separately billable by the facility. The Department shall retain its authority under s. 49.45(10), Wis. Stats., to modify this paragraph.

3.802 Oxygen

A nursing home may bill for oxygen in cubic feet, pounds, tanks or for the daily rental of oxygen concentrators. The nursing home must use the claim form approved by the Department for oxygen billing. The nursing home will be subject to maximum fees for these services. Prior authorization is required for more than 30 days' rental of an oxygen concentrator for a resident.

3.810 Add-Ons for Separately Billable Items

3.811 Ancillary Add-Ons

A per patient day add-on to the daily rate may be allowed for the cost incurred by the facility for specifically identified covered services and materials which could be billed separately to the Medicaid Program by an independent provider of service. These services and materials must be available to all Medicaid recipients of the facility. If some portion of the services and materials must be supplied by an outside provider, the facility is responsible for payment to the outside provider.

The maximum amount allowed a facility for an add-on shall be the estimated maximum reimbursement available to independent providers for such services and materials when billing the Medicaid Program separately. The Department may exclude all costs in excess of this maximum. Such costs shall be from the reporting period(s) specified by the Department. If an add-on is approved, then neither the facility nor independent provider or providers of service may bill or charge the Medicaid Program separately for the material or services which are covered by the add-on. If a special need arises, i.e., something not covered by the add-on for any resident, the facility must receive approval from the Department in advance, in order for an independent provider to be reimbursed for the service or material.

NOTE: Each facility with an ancillary must demonstrate that the add-on to the daily rate is equal to or less costly than if the service was reimbursed to an independent provider through separate billings. If a facility requests a new ancillary add-on, the facility must demonstrate to the Department that the add-on meets the requirement of this section before the add-on is approved. The method of reporting the estimated expenditure shall be specified by the Department.

3.812 Adjustment for Changes in Practice

It is possible that a facility may wish to begin or resume billing some services or materials separately, after having had ancillary add-ons previously incorporated into its daily rate. If that occurs, the Department may make a reasonable and appropriate off-setting

reduction to the facility's previous or current payment rate to exclude an ancillary add-on for the service. THE FACILITY SHALL NOTIFY THE DEPARTMENT OF THE CHANGE 30 DAYS PRIOR TO THE PROPOSED EFFECTIVE DATE.

3.900 REIMBURSEMENT OF STATE-OPERATED FACILITIES

3.910 General

The state-owned nursing facilities and ICF-MRs serve a unique population of residents in Wisconsin. Determination of payments will be guided by the provisions below and by the appropriate sections of state statute.

3.920 Direct Care, Support Services Administrative and General, Fuel and Utilities and Property Tax

The maximums and limitations in Sections 3.100 through Section 3.400 shall not be applied in determining payments to state-operated facilities. The amount of the final payment shall be based upon the actual and allowable costs in the cost reporting period. Interim rates and cost reconciliation procedures are described in Sections 3.960 and 3.980.

3.930 Ancillary Add-Ons

Actual and allowable ancillary expenses as described under Section 3.800 for a time period established by the Department shall be used to calculate the final ancillary add-on costs. Interim add-ons will be set as described in Section 3.960. Underpayments or overpayments for ancillary add-on costs shall be included in the reconciliation described in Section 3.980. The maximums and limitations in Section 3.610 shall not be applied in determining payments to these facilities.

3.940 Capital Costs

Actual and allowable capital expenses for the cost reporting period shall be used to calculate the final property allowance. The property allowance shall be subject to reconciliation under Section 3.980.

3.950 Reporting Limitations

The facilities shall be subject to all cost reporting requirements, and payments shall be limited to allowable costs described in Section 1.200. The costs of teaching and vocational counseling services rendered residents under age 22 as part of an active treatment plan are only allowable in facilities licensed as ICF-MRs. The facilities will maintain adequate records so that audits of costs may be conducted to determine payable costs.

3.960 Interim Payment Rates

Interim payment rates may be established and will be subject to the cost reconciliation under Section 3.980.

3.970 Reimbursement Limitation

Total reimbursement for the payment rate year for state-owned facilities for patient care shall not exceed the Medicare upper limit.

3.980 Cost Reconciliation

A cost reconciliation will be conducted at the end of each state-owned facility's fiscal year. If payment at the interim rates does not exceed the Medicare upper limit, then the facility will be reimbursed the difference. If the payments at the interim rates are above the Medicare upper limit, then the difference will be recovered. However, in no case shall the total Medicaid payment exceed the limitations described in Section 3.970.

SECTION 4.000 SPECIAL PAYMENT RATE ADJUSTMENTS AND RECALCULATIONS

4.100 RETROACTIVE RATE ADJUSTMENTS

4.110 Retroactivity

The Department has the authority to retroactively adjust the daily rate in such circumstances as audit adjustments, errors in reporting, errors in calculations, implementation of administrative formula provisions, and implementation of rules enacted under s. 49.45(10), Wis. Stats.

4.115 Administrative Reviews and Appeals

Sections 4.110 through 4.150 do not apply to administrative reviews under Section 1.800 or to appeals under Section 1.400 or Section 1.700. The time limits within which administrative reviews or appeals must be filed are determined under the relevant section, rule, and guidelines.

4.120 Material Adjustments

Only audit adjustments and/or corrections of errors which have a combined net material impact on rates and payments for services will be incorporated into the rates. "Material" is defined as the combined net increase or decrease being equal to or greater than an average change of $.050 per patient day. The average change shall be calculated on a weighted average of the change in each level of care payment rate using the patient days from the calculation of the average base rate (See Section 3.710). The materiality test will be applied separately each time payment rates are recalculated for the correction of errors or audit adjustments with the newly-adjusted rates being compared to the rates being corrected or adjusted.

4.130 Within 150 Days

A provider must deliver written notice of errors to the Department within 150 days of the date of the first rate approval letter in order for any corrected rates to take effect on the original effective date of the rates in error. A postmark date shall be considered delivery date. The provider will be limited to only one such retroactive adjustment per rate effective period in order to correct errors in reported data. Departmental corrections to the rate calculation mechanics of the Department shall not be limited to one such retroactive adjustment. Notice or approval of a corrected rate does not initiate a new 150-day period.

If errors are found by the Department, increased corrected rates will be effective on the first of the month following the month in which the error was found and decreased corrected rates will be effective on the original effective date of the rates being corrected. If such errors are found coincident to a notice from the provider of some other errors, then corrections for the findings of the Department shall be incorporated with and allowed to be retroactively effective in conjunction with the corrections resulting from the notice from the provider.

4.140 After 150 Days

If the provider delivers written notice of errors to the Department more than 150 days after the date of the first rate approval letter, corrected increased rates will be effective the first of the month following the month in which the notice was delivered to the Department. Corrected decreased rates from such notice shall be effective on the original effective date of the corrected rates. A postmark date shall be considered delivery date.

If errors are found by the Department, corrected increased rates will be effective the first of the month following the month in which found by the Department. Corrected decreased rates shall be effective on the original effective date of the rates being corrected. If such errors are found coincident to a notice from the provider of some other errors, then corrections for the findings of the Department shall be incorporated with and be effective in conjunction with the corrections resulting from the notice from the provider.

4.150 Audits

Any findings of the Department in the course of an audit shall be considered findings coincident to any written notice of errors delivered by the provider to the Department in the course of the audit. Such corrections submitted by the provider shall be taken into consideration in conjunction with and incorporated with any findings of the Department when determining audit adjusted payment rates. An audit shall be considered completed on the date of the approval letter of the audit adjusted payment rates. This completion date initiates the 150-day period described in Section 4.130.

4.200 CHANGE OF OWNERSHIP

4.210 No Rate Change for New Owner

There shall be no payment rate recalculation due to the change of ownership of a facility or operation which occurs during the payment rate year described in Section 1.130. The new provider will be paid the rate which the former owner was paid or would have been paid if no change of ownership had occurred, unless other provisions of this Section 4.000 allow adjustments to the payment rate. If the change of ownership occurred prior to the payment rate year, July 1 payment rates shall be determined based on a cost reporting period allowed under Section 1.302.

4.220 Prior Owner's Cost Report Required

The cost report for the period during which the facility was operated by the previous owner is still required and must be submitted to the Department unless the Department determines the cost report is not needed. THE NEW OWNER SHOULD ASSURE THE PRIOR OWNER'S COST REPORT IS SUBMITTED. The cost report is presumed to be needed in order for the Department to obtain sufficient data for a full twelve month base cost reporting period allowed under Section 1.302. In those rare instances where it may be impossible to obtain the prior owner's cost report, the Department may determine it is not needed if the cost reporting period for the new owner allowable under Section 1.302 covers a period of at least six months. If the prior owner's cost report is needed, but not submitted, the new provider's rates for the payment rate year specified in Section 1.130 will default to the facility's June 30th rate of the prior payment rate year, exclusive of any amounts for ancillary add-ons and Nursing Home Appeals Board awards and special allowances for local government operated facilities. The Department may reduce those rates by no more than 25.0% if deemed appropriate.

4.230 Property Tax

The property tax allowance shall not be adjusted to recognize a change in tax status upon a change of ownership.

4.300 PAYMENT RATES FOR NEW FACILITIES

4.301 General

Payment rates for a new facility will be established under the rate calculation provisions of Section 3.000. The rate computation will consist of two phases: (1) retrospective rates for the start-up period, and (2) post start-up period adjusted rates. The Department will establish interim rates until rates can be finalized under this section. New facilities are defined in Section 1.305. The Department may deny approval of any rates if any required Chapter 150 approval was not obtained. The Chapter 150 rate maximum per Section 1.600 shall apply, if applicable, to the new facility. Allowable costs will be deflated and inflated as appropriate with the indices in Section 5.300 and the provisions of the current Methods applied. The property allowance shall be calculated under the provisions of Section 3.500.

The provisions of Sections 4.300 through 4.360 shall not apply to the full or partial conversion of an NF to ICF-MR certification.

4.310 Start-Up Period

The start-up period shall be the twelve-month period beginning on the first of the month following the month in which the facility was licensed. A facility certified for the Medicaid Program after this twelve-month period shall be considered to have completed its start-up period.

4.320 Payment Rates During the Start-Up Period

Payment rates for the start-up period shall be retrospectively established based on one or more cost reports for the start-up period. The cost reporting period shall: (1) begin on, or within the five calendar months after, the date of certification for Medicaid, and (2) end on, or within the five calendar months after, the end date of the start-up period. The payment rates shall not be effective earlier than the certification date and shall lapse not later than at the end of the start-up period.

The minimum patient days for the administrative expense component (Section 3.230), the fuel and utility allowance (Section 3.300), the property tax allowance (Section 3.400), and the property allowance (Section 3.500) shall be the greater of patient days at 50.0% occupancy of average licensed beds or adjusted patient days during the cost reporting period.

4.330 Payment Rates After the Start-Up Period

After completion of the start-up period, rates for a new facility shall be reestablished based on at least a six-month cost report which will begin after the end of the start-up period or after the end of the cost reporting periods used under Section 4.320. The minimum patient day occupancy standards under Section 3.000 shall apply.

4.332 Modified Cost Report Period
The Department may modify the above start-up period and cost reporting requirements for special situations or to accommodate the fiscal year of a provider to permit more efficient or reliable cost reporting. Whenever possible, fuel and utility expense should cover a twelve-month period pursuant to Section 3.360.

4.333 Base Rates
The base rates for a newly-licensed facility are described in Section 3.722, item 4.

4.335 July 1 Payment Rates
A base cost reporting period shall be designated by the Department for establishing a new facility's payment rates for July 1 of the payment rate year described in Section 1.314. If the start-up period includes the July 1 date, then the July payment rates shall be established under the retrospective provisions for the start-up period. If the cost reporting fiscal year specified in Section 1.302 begins before or during the start-up period, then the Department may designate a more current base cost reporting period for July rates.

4.350 Inflationary Adjustment of Expenses
Cost data from any cost reporting period described above will be inflated or deflated to the common period described in Section 1.303.

4.360 Property Tax Allowance
The property tax allowance shall be based on the provisions of Section 3.400. Nevertheless, the provider may request the property tax allowance for a new facility to be adjusted if the expense in the previous tax allowance had been based on an assessment date prior to the month of licensure. The adjustment shall be effective on January 1 of the year in which payment of the tax or municipal service fees are due but not earlier than the first of the month in which the request is received by the Department. The adjustment shall only consider current expenses, without any inflationary adjustment, and patient days from the cost report period that was used for the support services allowance in the January 1 payment rate.

4.400 PAYMENT RATES FOR SIGNIFICANT INCREASES IN LICENSED BEDS

4.401 General
The Department may require or a provider may request the payment rate to be reestablished under the provisions of Section 3.000 when a provider significantly increases its unrestricted use licensed beds. The rate computations will consist of two phases: (1) retrospective rates for the start-up period, and (2) post start-up period adjusted rates.

The Department may establish interim rates until rates can be finalized under this section. A significant increase in licensed beds is defined in Section 1.304. The Department may deny approving any adjusted rates if any required Chapter 150 approval was not obtained. The Chapter 150 rate maximum per Section 1.600 shall apply, if applicable, to the expanded facility. The property allowance shall be recalculated under the provisions of Section 3.500.

The provisions of Sections 4.400 through 4.460 shall not apply to the full or partial conversion of an NF to ICF-MR certification.

4.410 Start-Up Period
The start-up period shall be the twelve-month period beginning on the first of the month following the month in which the new beds were licensed.

4.420 Payment Rates During the Start-Up Period
Application of this section is optional. Payment rates for the start-up period may be retrospectively established based on one or more cost reports for the start-up period for any or all applicable payment allowances. The cost reporting period shall: (1) begin on, or within the five calendar months after, the beginning date of the start-up period, and (2) end on, or within the five calendar months after, the end date of the start-up period. The adjusted payment rates shall be effective as of the date of amended licensure.

The minimum patient days for the administrative expense component (Section 3.250), the fuel and utility allowance (Section 3.300), the property tax allowance (Section 3.400), and the property allowance (Section 3.500) shall be the greater of adjusted patient days or patient days at the minimum occupancy rate described here. The minimum occupancy rate shall be based on: (1) 50.0% of the increase in licensed beds, and (2) the average daily occupancy in the six calendar months immediately preceding the increase in licensed beds during which no substantial number of licensed beds were out-of-use due to any renovation or construction. The occupancy rate in (2) above must be 90.5% or greater.